STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF SOCIAL SERVICES
744 P Street • Sacramento, CA 95814 • *www.cdss.ca.gov*

JOHN A. WAGNER
DIRECTOR

ARNOLD SCHWARZENEGGER
GOVERNOR

REASON FOR THIS TRANSMITTAL

[ ] State Law Change
[ ] Federal Law or Regulation Change
[ ] Court Order
[X] Clarification Requested by One or More Counties
[ ] Initiated by CDSS

June 27, 2008

ALL COUNTY INFORMATION NOTICE NO. I-49-08

TO: ALL COUNTY WELFARE DIRECTORS
ALL CalWORKs PROGRAM SPECIALISTS
ALL WELFARE TO WORK COORDINATORS
ALL COUNTY CONSORTIUM PROJECT MANAGERS
ALL REFUGEE PROGRAM COORDINATORS
ALL COUNTY FOOD STAMP COORDINATORS
ALL COUNTY CIVIL RIGHTS COORDINATORS

SUBJECT: CALIFORNIA WORK OPPORTUNITY AND RESPONSIBILITY TO KIDS (CalWORKs): REVISIONS TO CalWORKs NOTICES OF ACTION (NOA) FOR WELFARE TO WORK (WTW)

REFERENCE: All County Letter (ACL) 03-49; ACL 04-47

The purpose of this All-County Information Notice (ACIN) is to transmit new and revised CalWORKs Welfare-to-Work NOAs, which include revised budget calculations and language changes that will allow the forms to be more clearly translated to other languages. Grammatical changes have also been made.

NEW AND REVISED WTW FORMS

Listed below are the forms to be used in the CalWORKs sanction process. These new and revised forms must be used immediately and old stock destroyed.

- NA 816 Sanction of Other Parent After Failed Compliance Plan (Two-Parent Assistance Unit)
- NA 817 Sanction of Participant After Failed Compliance Plan
- NA 840 Sanction of Mandatory Participant
- NA 845 Sanction and Removal of the Other Parent's Needs (Two-Parent Assistance Unit)
- NA 1242 Sanctions Budget

SUMMARY OF REVISIONS

The budget calculation was removed from these forms and will now be included on a new continuation page, the NA 1242, which is to be attached to the NA 816, 817, 840, and 845. The budget calculation now included on the NA 1242 has been revised and updated. References to sanction durations have been removed because regulations no longer require a minimum sanction period; an individual may cure his or her sanction at any time. Reference to the current cash aid amount (Line 12) on the prior version of the budget calculation has been removed because it does not apply to a person who is subject to sanction. The NA 816, 817, 840, and 845 also include some language changes so that they may be more clearly translated to other languages. Please note that this includes changes to the titles of the NA 816 and NA 845 for translation purposes. Other grammatical changes have been made.

CAMERA-READY COPIES AND TRANSLATIONS

For a camera ready copy of English, contact the Forms Management Unit at (916) 657-1907. If your office has internet access, you may obtain these forms from the California Department of Social Services (CDSS) web page at: http://www.dss.cahwnet.gov/cdssweb/FormsandPu_271.htm.

When translations are completed, they are posted on an ongoing basis on our web site for use by the counties pursuant to Manual of Policies and Procedures Section 21-115.2. Copies of the translated forms and publications can be obtained at http://www.dss.cahwnet.gov/cdssweb/FormsandPu_274.htm. For questions on translated materials, please contact Language Services at (916) 651-8876.

If you have questions or need additional information regarding the information in this letter, please contact your CDSS Employment Bureau county consultant at (916) 654-2137.

Sincerely,

Original Document Signed By:

KÄREN DICKERSON, Chief
Employment and Eligibility Branch

Attachments

c: CWDA

NOTICE OF ACTION

COUNTY OF

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

Notice Date : _____
Case Name : _____
Number : _____
Worker Name : _____
Number : _____
Telephone: _____
Address : _____

(ADDRESSEE)

Questions? Ask your Worker.

State Hearing: If you think this action is wrong, you can ask for a hearing. The back of this page tells you how. Your benefits may not be changed if you ask for a hearing before this action takes place.

_____, as of _____, we are lowering your family's cash aid from $_____ to $_____ as shown on the following page. Cash aid will stop for you.

We are lowering your family's cash aid because you did not have a good reason for not doing what you agreed to do in the compliance plan that you signed. You agreed to: _____

_____

We will not pay for transportation, or work- or training-related expenses while you are off cash aid. We may pay for child care, if you work or attend school.

HOW TO GET YOURSELF BACK ON CASH AID

Your family's cash aid is being lowered because you did not do what we asked you to do and you are being removed from the Assistance Unit. If your family's cash aid is lowered, you can get your portion of the cash aid back if you are eligible for it by contacting the county and telling them you want your cash aid back; then doing what the county asks.

TO CONTACT THE COUNTY ABOUT GETTING BACK ON CASH AID, CALL _____.

The family's other parent, _____, may also get cash aid again if he/she is eligible for it by contacting the county and telling them he/she wants cash aid back; then doing what the county asks.

DO YOU NEED FREE LEGAL HELP? You can get free help with this problem from:

Local Legal Aid Office: ( )

_____

State Welfare Rights Organization: ( )

_____

Food Stamps: If the failure to meet Welfare to Work requirements also causes a food stamps penalty, you may not be able to get food stamps. If there is a food stamps penalty, you will get another notice telling you how long your food stamps will be stopped.

Medi-Cal: This Notice of Action does NOT change or stop Medi-Cal benefits. **Keep your plastic Benefits Identification Card(s).**

Rules: These rules apply: CalWORKs MPP § 42-712 (exemptions); 42-713 (good cause); 42-721 (noncompliance and good cause). Food Stamps MPP § 63-407.521. You may review these rules at your welfare office.

YOUR HEARING RIGHTS

You have the right to ask for a hearing if you disagree with any county action. You have only 90 days to ask for a hearing. The 90 days started the day after the county gave or mailed you this notice.

If you ask for a hearing <u>before</u> an action on Cash Aid, Medi-Cal, Food Stamps, or Child Care takes place:

- Your Cash Aid or Medi-Cal will stay the same while you wait for a hearing.
- Your Child Care Services may stay the same while you wait for a hearing.
- Your Food Stamps will stay the same until the hearing or the end of your certification period, whichever is earlier.

If the hearing decision says we are right, you will owe us for any extra Cash Aid, Food Stamps or Child Care Services you got. To let us lower or stop your benefits before the hearing, check below:

Yes, lower or stop: ☐ Cash Aid ☐ Food Stamps ☐ Child Care

While You Wait for a Hearing Decision for:

<u>Welfare to Work</u>:

You do not have to take part in the activities.

You may receive child care payments for employment and for activities approved by the county before this notice.

If we told you your other supportive services payments will stop, you will not get any more payments, even if you go to your activity.

If we told you we will pay your other supportive services, they will be paid in the amount and in the way we told you in this notice.

- To get those supportive services, you must go to the activity the county told you to attend.
- If the amount of supportive services the county pays while you wait for a hearing decision is not enough to allow you to participate, you can stop going to the activity.

<u>Cal-Learn</u>:

- You cannot participate in the Cal-Learn Program if we told you we cannot serve you.
- We will only pay for Cal-Learn supportive services for an approved activity.

OTHER INFORMATION

Medi-Cal Managed Care Plan Members: The action on this notice may stop you from getting services from your managed care health plan. You may wish to contact your health plan membership services if you have questions.

Child and/or Medical Support: The local child support agency will help collect support at no cost even if you are not on cash aid. If they now collect support for you, they will keep doing so unless you tell them in writing to stop. They will send you current support money collected but will keep past due money collected that is owed to the county.

Family Planning: Your welfare office will give you information when you ask for it.

Hearing File: If you ask for a hearing, the State Hearing Division will set up a file. You have the right to see this file before your hearing and to get a copy of the county's written position on your case at least two days before the hearing. The state may give your hearing file to the Welfare Department and the U.S. Departments of Health and Human Services and Agriculture. **(W&I Code Sections 10850 and 10950.)**

TO ASK FOR A HEARING:

- **Fill out this page.**
- Make a copy of the front and back of this page for your records. If you ask, your worker will get you a copy of this page.
- **Send or take this page to:**

OR

- **Call toll free: 1-800-952-5253 or** for hearing or speech impaired who use TDD, **1-800-952-8349**.

To Get Help: You can ask about your hearing rights or for a legal aid referral at the toll-free state phone numbers listed above. You may get free legal help at your local legal aid or welfare rights office.

If you do not want to go to the hearing alone, you can bring a friend or someone with you.

HEARING REQUEST

I want a hearing due to an action by the Welfare Department of _____ County about my:

☐ Cash Aid ☐ Food Stamps ☐ Medi-Cal

☐ Other (list) _____

Here's Why: _____

_____

_____

_____

_____

_____

☐ **If you need more space, check here and add a page.**

☐ I need the state to provide me with an interpreter at no cost to me. (A relative or friend cannot interpret for you at the hearing.)

My language or dialect is: _____

NAME OF PERSON WHOSE BENEFITS WERE DENIED, CHANGED OR STOPPED

BIRTH DATE | PHONE NUMBER

STREET ADDRESS

CITY | STATE | ZIP CODE

SIGNATURE | DATE

NAME OF PERSON COMPLETING THIS FORM | PHONE NUMBER

☐ **I want the person named below to represent me at this hearing. I give my permission for this person to see my records or go to the hearing for me. (This person <u>can be</u> a friend or relative but cannot interpret for you.)**

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STREET ADDRESS

CITY | STATE | ZIP CODE

NOTICE OF ACTION

COUNTY OF

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

Notice Date : _____
Case Name : _____
Number : _____
Worker Name : _____
Number : _____
Telephone: _____
Address : _____

(ADDRESSEE)

Questions? Ask your Worker.

State Hearing: If you think this action is wrong, you can ask for a hearing. The back of this page tells how. Your benefits may not be changed if you ask for a hearing before this action takes place.

_____, as of _____, we are changing your family's cash aid from $_____ to $_____ as shown on the following page.

We are lowering your family's cash aid because you did not have a good reason for not doing what you agreed to do in the compliance plan that you signed. You agreed to:

_____

_____

We will not pay for transportation, or work- or training-related expenses while you are off cash aid. We may pay for child care, if you work or attend school.

HOW TO GET YOURSELF BACK ON CASH AID

Your family's cash aid is being lowered because you did not do what we asked you to do and you are being removed from the Assistance Unit. If your family's cash aid is lowered, you can get your portion of the cash aid back if you are eligible for it by contacting the county and telling them you want your cash aid back; then doing what the county asks.

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_____

State Welfare Rights Organization: ( )

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- Your Child Care Services may stay the same while you wait for a hearing.
- Your Food Stamps will stay the same until the hearing or the end of your certification period, whichever is earlier.

If the hearing decision says we are right, you will owe us for any extra Cash Aid, Food Stamps or Child Care Services you got. To let us lower or stop your benefits before the hearing, check below:

Yes, lower or stop: ☐ Cash Aid ☐ Food Stamps ☐ Child Care

While You Wait for a Hearing Decision for:

<u>Welfare to Work</u>:

You do not have to take part in the activities.

You may receive child care payments for employment and for activities approved by the county before this notice.

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If we told you we will pay your other supportive services, they will be paid in the amount and in the way we told you in this notice.

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- You cannot participate in the Cal-Learn Program if we told you we cannot serve you.
- We will only pay for Cal-Learn supportive services for an approved activity.

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If you do not want to go to the hearing alone, you can bring a friend or someone with you.

HEARING REQUEST

I want a hearing due to an action by the Welfare Department of _____ County about my:

☐ Cash Aid ☐ Food Stamps ☐ Medi-Cal

☐ Other (list) _____

Here's Why: _____

_____

_____

_____

_____

_____

☐ **If you need more space, check here and add a page.**

☐ I need the state to provide me with an interpreter at no cost to me. (A relative or friend cannot interpret for you at the hearing.)

My language or dialect is: _____

NAME OF PERSON WHOSE BENEFITS WERE DENIED, CHANGED OR STOPPED

BIRTH DATE | PHONE NUMBER

STREET ADDRESS

CITY | STATE | ZIP CODE

SIGNATURE | DATE

NAME OF PERSON COMPLETING THIS FORM | PHONE NUMBER

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NOTICE OF ACTION

COUNTY OF

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

Notice Date : _____
Case Name : _____
Number : _____
Worker Name : _____
Number : _____
Telephone: _____
Address : _____

(ADDRESSEE)

Questions? Ask your Worker.

State Hearing: If you think this action is wrong, you can ask for a hearing. The back of this notice tells how. Your benefits may not be changed if you ask for a hearing before this action takes place.

_____, our records show that you did not:

- ☐ Sign the Welfare to Work plan on _____.
- ☐ Participate in _____ on _____.
- ☐ Make good progress in your _____ activity because _____ .
- ☐ Accept a job at _____.
- ☐ Keep your job at _____.
- ☐ Keep the same amount of earnings.

WE NEED TO TALK TO YOU

To keep your family's cash aid from being lowered, we must talk with you about this problem. An appointment has been made for you on _____, at _____ o'clock, at _____. If you need transportation or child care to go to this meeting, call your Welfare to Work worker at the telephone number listed below.

Welfare to Work Worker's Name: _____
Telephone Number: _____

If you cannot go to this meeting, you must call your worker to set a new time. Unless you have a good reason, you can change this meeting only once. You can also call your worker to talk about the problem instead of going to the meeting. You must call your worker to set a new time to meet, or to talk about your problem on the telephone, by _____ .

When you talk to your worker, you will be asked if you had a good reason ("good cause") for not doing what we asked you to do. If we verify that you had a good reason, your family's cash aid will not be lowered because of this problem. Some examples of good reasons are not having child care or not having transportation. For other good reasons, see the "Request For Good Cause Determination" form sent with this notice.

Your family's cash aid will also not be lowered if you can show us that you should have been exempt at the time you did not do your Welfare to Work activity.

If you do not have a good reason for not doing what we asked you to do, you can agree to a compliance plan to meet Welfare to Work rules. Your family's cash aid will not be lowered if you agree to a compliance plan and then do what it says. If you agree to a compliance plan and then later do not do what it says, your family's cash aid will be lowered. If this happens, you will get a separate notice.

Rules: These rules apply: CalWORKs MPP § 42-712 (exemptions); 42-713 (good cause); 42-721 (noncompliance and good cause). Food Stamps MPP § 63.407.521. You may review these rules at your welfare office.

HOW TO STOP YOUR FAMILY'S CASH AID FROM BEING LOWERED

As of _____, your family's cash aid will be lowered from $ _____ to $ _____ as shown on the following page, unless you show us you had a good reason for not doing what we asked you to do. If you do not have a good reason, you can agree to a compliance plan to keep your family's cash aid from being lowered. If you do not agree to a compliance plan, you will not get another notice before your family's cash aid is lowered.

See the next page for more information about how we figured how much your family will get if your family's cash aid is lowered.

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_____

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_____

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☐ Other (list) _____

Here's Why: _____

_____

_____

_____

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My language or dialect is: _____

NAME OF PERSON WHOSE BENEFITS WERE DENIED, CHANGED OR STOPPED

BIRTH DATE | PHONE NUMBER

STREET ADDRESS

CITY | STATE | ZIP CODE

SIGNATURE | DATE

NAME OF PERSON COMPLETING THIS FORM | PHONE NUMBER

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CITY | STATE | ZIP CODE

NOTICE OF ACTION

COUNTY OF

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

Notice Date : _____
Case Name : _____
Number : _____
Worker Name : _____
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Telephone: _____
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(ADDRESSEE)

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- Your Child Care Services may stay the same while you wait for a hearing.
- Your Food Stamps will stay the same until the hearing or the end of your certification period, whichever is earlier.

If the hearing decision says we are right, you will owe us for any extra Cash Aid, Food Stamps or Child Care Services you got. To let us lower or stop your benefits before the hearing, check below:

Yes, lower or stop: ☐ Cash Aid ☐ Food Stamps ☐ Child Care

While You Wait for a Hearing Decision for:

<u>Welfare to Work</u>:

You do not have to take part in the activities.

You may receive child care payments for employment and for activities approved by the county before this notice.

If we told you your other supportive services payments will stop, you will not get any more payments, even if you go to your activity.

If we told you we will pay your other supportive services, they will be paid in the amount and in the way we told you in this notice.

- To get those supportive services, you must go to the activity the county told you to attend.
- If the amount of supportive services the county pays while you wait for a hearing decision is not enough to allow you to participate, you can stop going to the activity.

<u>Cal-Learn</u>:

- You cannot participate in the Cal-Learn Program if we told you we cannot serve you.
- We will only pay for Cal-Learn supportive services for an approved activity.

OTHER INFORMATION

Medi-Cal Managed Care Plan Members: The action on this notice may stop you from getting services from your managed care health plan. You may wish to contact your health plan membership services if you have questions.

Child and/or Medical Support: The local child support agency will help collect support at no cost even if you are not on cash aid. If they now collect support for you, they will keep doing so unless you tell them in writing to stop. They will send you current support money collected but will keep past due money collected that is owed to the county.

Family Planning: Your welfare office will give you information when you ask for it.

Hearing File: If you ask for a hearing, the State Hearing Division will set up a file. You have the right to see this file before your hearing and to get a copy of the county's written position on your case at least two days before the hearing. The state may give your hearing file to the Welfare Department and the U.S. Departments of Health and Human Services and Agriculture. **(W&I Code Sections 10850 and 10950.)**

TO ASK FOR A HEARING:

- **Fill out this page.**
- Make a copy of the front and back of this page for your records. If you ask, your worker will get you a copy of this page.
- **Send or take this page to:**

OR

- **Call toll free: 1-800-952-5253 or** for hearing or speech impaired who use TDD, **1-800-952-8349**.

To Get Help: You can ask about your hearing rights or for a legal aid referral at the toll-free state phone numbers listed above. You may get free legal help at your local legal aid or welfare rights office.

If you do not want to go to the hearing alone, you can bring a friend or someone with you.

HEARING REQUEST

I want a hearing due to an action by the Welfare Department of _____ County about my:

☐ Cash Aid ☐ Food Stamps ☐ Medi-Cal

☐ Other (list) _____

Here's Why: _____

_____

_____

_____

_____

_____

☐ **If you need more space, check here and add a page.**

☐ I need the state to provide me with an interpreter at no cost to me. (A relative or friend cannot interpret for you at the hearing.)

My language or dialect is: _____

NAME OF PERSON WHOSE BENEFITS WERE DENIED, CHANGED OR STOPPED

BIRTH DATE | PHONE NUMBER

STREET ADDRESS

CITY | STATE | ZIP CODE

SIGNATURE | DATE

NAME OF PERSON COMPLETING THIS FORM | PHONE NUMBER

☐ **I want the person named below to represent me at this hearing. I give my permission for this person to see my records or go to the hearing for me. (This person <u>can be</u> a friend or relative but cannot interpret for you.)**

NAME | PHONE NUMBER

STREET ADDRESS

CITY | STATE | ZIP CODE

NOTICE OF ACTION
(Continued)

COUNTY OF

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

Notice Date : _____
Case Name : _____
Number : _____

You reported the following income for the quarter.

Month _____ | |
Month _____ | |
Month _____ | |

Monthly Cash Aid Amount

Section A. Countable Income

Total Self-Employment Income . . . . . $ _____
Self-Employment Expenses:
a. 40% Standard . . . . . - _____
OR
b. Actual . . . . . - _____
Net Earnings from Self-Employment . . . . . = _____

Total Disability-Based Unearned Income
(Assistance Unit + Non-Assistance Unit Members) . . . . . $ _____
$225 Disregard . . . . . - _____
Nonexempt Unearned Disability-Based Income . . . . . = _____
OR
Unused Amount of $225 Disregard . . . . . = _____

Total Earned Income . . . . . $ _____
Net Earnings from Self-Employment (from above) . . . . . + _____
Subtotal . . . . . = _____
Unused Amount of $225 Disregard (from above) . . . . . - _____
Subtotal . . . . . = _____
Earned Income Disregard 50% . . . . . - _____
Subtotal . . . . . = _____
Nonexempt Unearned Disability-Based Income
(from above). . . . . + _____
Other Nonexempt Income (Assistance Unit + Non-
Assistance Unit Members)_____ + _____
_____ + _____
Net Countable Income . . . . . = _____

Section B. Your Cash Aid

1. Maximum Aid _____ Persons
(Assistance Unit + Non-Assistance Unit Members) . . $ _____
2. Special Needs (Assistance Unit + Non-Assistance
Unit Members) . . . . . + _____
3. Net Countable Income from Section A . . . . . - _____
4. Subtotal . . . . . = _____
5. Maximum Aid _____ Persons (Assistance Unit only)
(Excluding MFG, or Penalized Persons) . . . . . $ _____
6. Special Needs (Assistance Unit only) . . . . . + _____
7. Maximum Aid Subtotal . . . . . = _____
8. **Full Month Aid Subtotal**
(Lowest Amount on Line 4 or 7) . . . . . = _____
9. Adjustments: 25% Child Support Penalty(ies) . . . . - _____
Overpayment . . . . . - _____
Cal-Learn Penalty(ies) . . . . . - _____
Cal-Learn Bonus . . . . . + _____
10. **Monthly Cash Aid Amount**
(Line 8 Adjusted) . . . . . = _____